TTx Medication Hx Consent Form

Transcendent Therapeutics LLC
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Patient's Name:_____ Date of Birth: _____

By signing below you hereby agree to the terms and conditions outlined below granting my provider, Stacy Veo, access to your medication history via the protected EHR (RXNT) system. This history will display any prescriptions that have been written for you over the last year from all providers.
I agree to the terms of this service and I authorize my provider, Stacy Veo, to view and access my medication history. I understand that I have the right to revoke consent in writing at any time to discontinue this service.

_____ Date:_____
Patient's signature

_____
Parent/Guardian Signature if patient is under the age of 18 Years old.